

eTG
complete

What's new, and why?

November 2011 Update


Therapeutic
Guidelines
evidence in context

New information and major
changes in **eTG complete**
and **miniTG**

New-look design

The first thing that eTG complete users will notice is the new design format that includes a fresh colour scheme, highlighted 'i-buttons' and new-look tables and information boxes. A key improvement in this release is the inclusion of a breadcrumb trail at the top of each page. This feature is designed to aid navigation and to assist users to easily see where information on a particular topic is placed within the overall content of eTG complete.

Diagnostic approach to fatigue in primary care

Background

This new topic takes a different approach from previous Therapeutic Guidelines topics because it focuses on diagnosis rather than therapeutics. It is a small topic that considers patients who present with fatigue in general practice. The topic is split into sections to help readers find what they are after, but is designed to be read from beginning to end as useful background rather than during consultations with patients.

Conditions commonly associated with fatigue

Although fatigue is often explained by significant psychosocial factors, potential underlying diseases must always be considered. In a large proportion of patients fatigue remains unexplained. The topic discusses conditions commonly associated with fatigue and links to their therapeutic management in other topics within eTG complete.

Diagnostic process

The expert group has emphasised the importance of the diagnostic approach in patients who present with fatigue. A targeted history and examination is an essential part of the clinical assessment.

Pathology investigations are often requested, even when underlying disease is thought to be unlikely based on the history and examination. Pathology testing has inherent limitations and has to be applied intelligently, mindful of the clinical context. The topic discusses when investigations might be necessary, and gives examples to highlight the pitfalls of testing when the pre-test probability of an underlying disease seems small. Red flags that should raise the suspicion of serious underlying disease are also included.

The passage of time is often a worthwhile diagnostic tool. When the pre-test probability of an underlying disease seems small, investigation is often best delayed until the clinical probability of an underlying disease becomes greater.

The clinical history is the most important tool for evaluating patients with fatigue.

Always consider the risks and benefits of investigations, especially when the pre-test probability of disease is small.

Specific patient age groups

Specific patient age groups are discussed to highlight factors to consider in each group. Five groups are considered—children, adolescents, young to middle-aged women, young to middle-aged men, and older people. Advice is given about when to have a higher index of suspicion for serious underlying disease (eg in older people with recent onset of fatigue).

Fatigue in patients with pre-existing conditions

Fatigue is a common symptom of existing disease. The expert group recognised the importance of keeping an open mind when considering the cause of fatigue in patients with pre-existing conditions. For example, fatigue in a patient receiving palliative care may not be due to the underlying disease.

Patients with persistent unexplained fatigue

After excluding significant organic disease and psychological illness, many patients remain troubled by some degree of persistent fatigue, often accompanied by other somatic symptoms. Unless significant new symptoms or physical signs emerge, further or repeated investigations are often unhelpful and unnecessary and risk encouraging the patient to brood about the ‘disease’ itself. The need for a compassionate therapeutic relationship between the primary care provider and the patient with persistent unexplained fatigue is emphasised.

In patients with persistent unexplained fatigue, further or repeated investigations are often unhelpful and unnecessary unless significant new symptoms or physical signs emerge.

Ulcer and wound management

Ulcer and wound management was prepared by a multidisciplinary expert group. It provides practitioners with distilled expert advice on how to deal with a set of clinical problems that may be commonplace (eg skin tears), or can be difficult to manage (eg chronic ulcers that are slow to heal or not expected to heal).

The general approach to a patient with a chronic wound or ulcer is summarised in [Figure 15.1](#). The initial decision is whether healing can be expected or not, and then what to do in either case. The need to address aetiological and contributing factors where possible, and to identify and deal with a number of associated patient-centred factors (eg pain control, exudate and odour management, and the financial burden) is outlined.

Assessing patients with a chronic ulcer or wound

The important aspects of assessing someone with a chronic wound or ulcer are discussed, and summarised in [Box 15.1](#). Detailed information is given about relevant aspects of the history, examination and appropriate investigations.

Assessment is not limited to the ulcer or wound, and should include the relevant limb or region, and the person as a whole. Possible associated conditions, and the impact of the wound on the person’s life, should also be assessed.

Wound swabs are used to identify an organism when there is clinical suspicion of invasive

Comprehensive assessment is the key to effective ulcer and wound management.

Wound swabs should not be used to decide if a wound is infected.

infection requiring systemic therapy, not to decide whether or not the wound is infected.

The ankle brachial pressure index (ABPI) is an important adjunct to clinical assessment before compression therapy. It is the most reliable way to detect hidden arterial disease. Its role in vascular assessment is described.

An objective and simple method of screening for peripheral neuropathy is provided—peripheral neuropathy makes development of ulcers on the feet much more likely unless appropriate preventive care is taken.

Skin tears

Skin tears often result from minor trauma to the lower limbs of people with fragile skin, and typically occur in older people. Common risk factors are discussed, and preventive strategies are explained.

The skin tear audit research (STAR) classification, used to guide the treatment of skin tears, is illustrated in a number of photographs.

Adhesive dressings (eg SteriStrips, tapes) should not be used to manage skin flap positioning or retention, due to the risk of damage on removal. A cohesive or tubular retention bandage can be used to retain dressings in place.

Venous leg ulcer

Common clinical features, and various aspects of treating venous leg ulcers, are described. There is a detailed discussion about the place of compression therapy, which is the cornerstone of treatment for venous leg ulcers. Patient education is important,

Adhesive dressings or tapes should not be used to manage skin flap positioning or retention.

Graduated compression therapy is the cornerstone of treatment for venous leg ulcers.

especially because of the need for long-term compression therapy. Reasons for delayed healing are discussed as well as factors associated with recurrence of venous ulcers and the best way of preventing recurrence.

Leg ulcer due to peripheral arterial disease

Peripheral arterial disease (PAD) is common in older people. All patients with leg ulcers should be assessed for PAD. Common clinical features of ulcers due to PAD are described, as is the impact of PAD on wound healing and the role of measuring the ankle brachial pressure index (ABPI). Discussion about treating ulcers due to PAD emphasises that a nonhealing ulcer in a patient with PAD is not of itself an indication for revascularisation.

Diabetic foot ulcer

Foot ulceration is a serious complication of diabetes that can lead to limb amputation or life-threatening infection. Prevention is the key to managing the diabetic foot. Links to appropriate foot care and monitoring in the section on diabetes complications are included. There is also a link to the appropriate antibiotic treatment recommendations for diabetic foot infections.

Pressure ulcer

Pressure ulcers usually result from pressure over a bony prominence. Advice is given about assessing and managing pressure ulcers. As well as reducing pressure, shearing forces and friction, other strategies are described. [Figure 15.3](#) summarises the approach to pressure ulcer management.

Prevention is the key to managing the diabetic foot.

Pressure ulcers can threaten a patient's life or limb, decrease quality of life and are expensive to treat.

Less common ulcers

Less common ulcers are primarily a result of skin pathology, rather than being secondary to underlying pathology. The clinical presentation and management of the following less common ulcers are discussed:

- › pyoderma gangrenosum
- › vasculitic ulcer
- › *Mycobacterium ulcerans* ulcer
- › dermatitis artefacta.

Bacterial issues relating to wound management

Ulcers can occur as a result of a primary infectious disease, although this is not common. Alternatively, ulcers with noninfectious causes (eg pressure, venous or arterial disease) can have a secondary infection.

This section describes when to culture chronic ulcers, the relevant clinical signs of infection, and the circumstances when the use of systemic antimicrobial therapy should be considered.

Topical antibiotics are not recommended as they may act as sensitising agents, have no demonstrated effect on healing, and can promote resistance in recognised pathogens.

Dermatitis (eczema)

Some degree of dermatitis or eczema is common in patients with chronic ulcers. Appropriate skin care for both prevention and management of chronic ulcers is discussed.

Topical antibiotics are not recommended in treating chronic ulcers.

Nutrition

Advice is given about the role of nutritional therapy in wound healing.

Effect of medicines on wound healing

Various prescribed, over-the-counter, and complementary and alternative medicines (CAM) can affect wound healing, either positively or negatively. A formal medication review is recommended for patients with complex wounds who meet relevant criteria. There is discussion about various medicines that inhibit wound healing and also medicines that might help wound healing.

Wound-related pain

Control of wound-related pain is important—not only to relieve suffering, but also because inadequately controlled pain delays wound healing. Usually the most effective approach is multidimensional, as described in [Figure 15.4](#). A number of key considerations for managing wound-related pain are highlighted and discussed.

Ulcers that are slow to heal

Most ulcers heal after using appropriate dressings and correcting underlying factors. However, some ulcers fail to heal as rapidly as expected, and various possible causes and approaches to care are discussed.

Wounds not expected to heal

Wounds that are unlikely to heal can be a challenge. Various physical, clinical, environmental and social factors can impair the process of wound healing to the extent that healing is unlikely, if not impossible. Whatever the reasons for impaired wound healing, and whether they are temporary or ongoing, the

Almost all wounds are painful.

broad approach to local wound management is the same. However, dressing choice may be affected, and approaches to managing odour, pain and bleeding are discussed.

When to refer

Specialist wound clinics and health practitioners are vital resources for wound management. The practitioner is given clear advice about when referral is appropriate.

Wound therapies

The section on wound therapies discusses different kinds of wound dressings, a number of specific wound conditions, various aspects of compression therapy, the role and types of debridement available, the place of pressure redistribution devices (summarised in [Table 15.6](#)) and some adjunctive and advanced therapies.

Wound dressings

Various aspects of wound dressings are discussed in detail, including the importance of achieving moisture balance, the six broad modern classes of dressings, cost, methods of retaining dressings and factors determining the frequency of dressing changes. The different types of dressing, their function, and some examples are listed in [Table 15.3](#) and [Table 15.4](#).

Specific wound conditions

Appropriate dressings for a number of types of wound and wound conditions, selected on the basis of maintaining optimal moisture balance, are outlined. These include: moist necrotic/sloughy wound, dry necrotic wound, highly exudative wound, dry nonexudative wound, superficial clean wound, heavily colonised wound, malodorous (smelly) wound, and fragile and painful wound. There is also

discussion about the skin around the wound, and hypergranulation tissue.

Compression

Compression is used to treat venous leg ulcers that are secondary to venous insufficiency and lymphoedema. It assists healing by reducing venous hypertension, enhancing venous return (by improving calf muscle pump function) and reducing peripheral oedema. It is important to undertake appropriate assessment before compression therapy to be able to decide whether to use compression, and the level that is appropriate.

Additionally, patients need to be warned about the risks of compression therapy — the warning symptoms and signs are discussed in a patient advice sheet (see [Box 15.2](#)).

Review and assessment for skin complications is recommended 24 to 48 hours after starting compression therapy.

Debridement

Debridement is an important step in preparing the wound bed for healing. Choice of the most appropriate debridement method is influenced by many factors, which are discussed. Options include autolytic, sharp, surgical, mechanical, biological and enzymatic.

Pressure redistribution

Pressure redistribution (pressure off-loading) devices are essential for healing certain wounds, especially those with a neuropathic component. Most of the devices (which are listed in [Table 15.6](#)) are specialised and need appropriately trained therapists (usually a podiatrist and/or orthotist) to fit them and advise on their use.

Compression therapy can cause harm, particularly if the patient has unrecognised arterial disease.

Modern wound dressings include hydrogels, films, hydrocolloids, absorbent fibres, hydroactive polymers, and polyurethane foams.

The moisture level of a wound can have a significant effect on its healing.



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